		FOR OHF USE					

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2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0016220

Facility Name: APOSTOLIC CHRISTIAN TIMBER RIDGE

Address: 2125 VETERANS ROAD (Number) MORTON (City) 61550 (Zip Code)

County: TAZEWELL

Telephone Number: (309) 266-9781 **Fax #** (309) 266-9468

IDPA ID Number: 23-7033585-001

Date of Initial License for Current Owners: 10/10/1971

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code	501(c)(3)		Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: MATTHEW D. STEFFEN **Telephone Number:** (309) 266-9781

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/2002 to 06/30/2003 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) RON MESSNER
(Title) ADMINISTRATOR

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number APOSTOLIC CHRISTIAN TIMBER RIDGE # 0016220 Report Period Beginning: 07/01/2002 Ending: 06/30/2003

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 12/01/1994

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4	98	Intermediate/DD	98	35,770	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	98	TOTALS	98	35,770	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	34,463	365		34,828	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	34,463	365		34,828	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 97.37%

D. How many bed-hold days during this year were paid by Public Aid?
292 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 10/01/1971

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified and days of care provided

Medicare Intermediary

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 06/30/2003 Fiscal Year: 06/30/2003

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number APOSTOLIC CHRISTIAN TIMBER RIDGE # 0016220 Report Period Beginning: 07/01/2002 Ending: 06/30/2003

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	252,807	13,235	4,494	270,536	(125)	270,411		270,411			1
2	Food Purchase		158,982		158,982		158,982		158,982			2
3	Housekeeping	98,464	11,816		110,280		110,280		110,280			3
4	Laundry	117,359	9,983		127,342	466	127,808		127,808			4
5	Heat and Other Utilities			75,679	75,679		75,679		75,679			5
6	Maintenance	79,696	18,711	32,727	131,134	8,826	139,960	(20,721)	119,239			6
7	Other (specify):*			2,261	2,261		2,261	(2,261)				7
8	**TOTAL General Services**	548,326	212,727	115,161	876,214	9,167	885,381	(22,982)	862,399			8
	B. Health Care and Programs											
9	Medical Director			1,332	1,332		1,332		1,332			9
10	Nursing and Medical Records	775,704	176,692	82,201	1,034,597	(18,309)	1,016,288	(11,078)	1,005,210			10
10a	Therapy	1,531,876	5,751	65,495	1,603,122	(1,587)	1,601,535		1,601,535			10a
11	Activities	223,147	8,390		231,537	171	231,708		231,708			11
12	Social Services	183,854	2,153	4,200	190,207	(11,685)	178,522		178,522			12
13	Nurse Aide Training	22,135	3,234		25,369	32,570	57,939		57,939			13
14	Program Transportation			39,477	39,477	(8,448)	31,029	(19,109)	11,920			14
15	Other (specify):* Day Programming	104,820	2,247		107,067		107,067	(107,067)				15
16	**TOTAL Health Care and Programs**	2,841,536	198,467	192,705	3,232,708	(7,288)	3,225,420	(137,254)	3,088,166			16
	C. General Administration											
17	Administrative	77,527			77,527	(284)	77,243		77,243			17
18	Directors Fees											18
19	Professional Services			20,012	20,012		20,012		20,012			19
20	Dues, Fees, Subscriptions & Promotions			21,026	21,026		21,026	(5,432)	15,594			20
21	Clerical & General Office Expenses	104,963	31,640	15,657	152,260	1,495	153,755		153,755			21
22	Employee Benefits & Payroll Taxes			865,514	865,514		865,514	(25,396)	840,118			22
23	Inservice Training & Education			4,612	4,612		4,612		4,612			23
24	Travel and Seminar			5,608	5,608		5,608	(3,929)	1,679			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			40,002	40,002		40,002		40,002			26
27	Other (specify):*			20,444	20,444	(20,144)	300	(300)				27
28	**TOTAL General Administration**	182,490	31,640	992,875	1,207,005	(18,933)	1,188,072	(35,057)	1,153,015			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,572,352	442,834	1,300,741	5,315,927	(17,054)	5,298,873	(195,293)	5,103,580			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number APOSTOLIC CHRISTIAN TIMBER RIDGE #0016220 Report Period Beginning: 07/01/2002 Ending: 06/30/2003

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			138,659	138,659		138,659	(16,902)	121,757			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			158	158		158		158			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			4,435	4,435	(644)	3,791		3,791			35
36	Other (specify):* **Invesment Fees**			24,277	24,277		24,277	(24,277)				36
37	**TOTAL Ownership**			167,529	167,529	(644)	166,885	(41,179)	125,706			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation					8,448	8,448	(8,448)				38
39	Ancillary Service Centers					9,250	9,250		9,250			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			269,144	269,144		269,144		269,144			42
43	Other (specify):* **Facility Bulletin**			1,943	1,943		1,943		1,943			43
44	**TOTAL Special Cost Centers**			271,087	271,087	17,698	288,785	(8,448)	280,337			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,572,352	442,834	1,739,357	5,754,543		5,754,543	(244,920)	5,509,623			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number APOSTOLIC CHRISTIAN TIMBER RIDGE # 0016220 Report Period Beginning: 07/01/2002 Ending: 06/30/2003

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$ (20,721)	6	$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs	(107,067)	15		3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(24,277)	36		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(2,835)	20		18
19	Entertainment				19
20	Contributions	(300)	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(2,597)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(87,123)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (244,920)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (244,920)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.	X		$ 8,448	14	38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$ 8,448		47

STATE OF ILLINOIS

APOSTOLIC CHRISTIAN TIMBER RIDGE

ID# 0016220

Report Period Beginning: 07/01/2002

Ending: 06/30/2003

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Offset day draining transportation income	$ (11,078)	10	1
2	Offset day draining transportation income	(19,109)	14	2
3	Out-of-state travel	(3,929)	24	3
4	Depreciation of non-care vehicles	(16,902)	30	4
5	Offset medically necessary transportation income	(8,448)	38	5
6	Benefits allocated to day programming	(25,396)	22	6
7	Loss on Sale of Assets	(2,261)	7	7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(87,123)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number APOSTOLIC CHRISTIAN TIMBER RIDGE # 0016220 **Report Period Beginning:** 07/01/2002 **Ending:** 06/30/2003

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(20,721)	0	0	0	0	0	0	0	0	0	0	(20,721)	6
7	Other (specify):*	(2,261)	0	0	0	0	0	0	0	0	0	0	(2,261)	7
8	**TOTAL General Services**	(22,982)	0	0	0	0	0	0	0	0	0	0	(22,982)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(11,078)	0	0	0	0	0	0	0	0	0	0	(11,078)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	(19,109)	0	0	0	0	0	0	0	0	0	0	(19,109)	14
15	Other (specify):*	(107,067)	0	0	0	0	0	0	0	0	0	0	(107,067)	15
16	**TOTAL Health Care and Programs**	(137,254)	0	0	0	0	0	0	0	0	0	0	(137,254)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(5,432)	0	0	0	0	0	0	0	0	0	0	(5,432)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	(25,396)	0	0	0	0	0	0	0	0	0	0	(25,396)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(3,929)	0	0	0	0	0	0	0	0	0	0	(3,929)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(300)	0	0	0	0	0	0	0	0	0	0	(300)	27
28	**TOTAL General Administration**	(35,057)	0	0	0	0	0	0	0	0	0	0	(35,057)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(195,293)	0	0	0	0	0	0	0	0	0	0	(195,293)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number APOSTOLIC CHRISTIAN TIMBER RIDGE # 0016220 **Report Period Beginning:** 07/01/2002 **Ending:** 06/30/2003

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(16,902)	0	0	0	0	0	0	0	0	0	0	(16,902)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	(24,277)	0	0	0	0	0	0	0	0	0	0	(24,277)	36
37	**TOTAL Ownership**	(41,179)	0	0	0	0	0	0	0	0	0	0	(41,179)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	(8,448)	0	0	0	0	0	0	0	0	0	0	(8,448)	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	(8,448)	0	0	0	0	0	0	0	0	0	0	(8,448)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(244,920)	0	0	0	0	0	0	0	0	0	0	(244,920)	45

Facility Name & ID Number APOSTOLIC CHRISTIAN TIMBER RIDGE # 0016220 Report Period Beginning: 07/01/2002 Ending: 06/30/2003

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Apostolic Christian Home for the Handicapped, Inc.	100%	Oakwood Estate Linden Estate	Morton Morton	Community Residential Services	Morton	Services for the Disabled

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number APOSTOLIC CHRISTIAN TIMBER RIDG # 0016220 Report Period Beginning: 07/01/2002 Ending: 06/30/2003

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Edward Sauder	Chairman	Director	0.00		0.5			$		1
2	John Knobloch	Vice Chairman	Director	0.00		0.5					2
3	Dan Schumacher	Sec/ Treasurer	Director	0.00		1					3
4	Jerry Christensen	Director	Director	0.00		0.5					4
5	Ron Gasser	Director	Director	0.00	619	0.5		Travel	1,135	line 24; col.3	5
6	Jerry Kieser	Director	Director	0.00		0.5					6
7	Keith Pflum	Director	Director	0.00	263	0.5		Travel	482	line 24; col.3	7
8	Richard Steffen	Director	Director	0.00		0.5					8
9	Stan Virkler	Director	Director	0.00	152	0.5		Travel	274	line 24; col.3	9
10	Warren Zahner	Director	Director	0.00	748	0.5		Travel	1,352	line 24; col.3	10
11											11
12											12
13								TOTAL	$ 3,243		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number APOSTOLIC CHRISTIAN TIMBER RIDGE # 0016220 Report Period Beginning: 07/01/2002 Ending: 6/30/2003

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number APOSTOLIC CHRISTIAN TIMBER RIDGE # 0016220 Report Period Beginning: 07/01/2002 Ending: 06/30/2003

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	**TOTAL Facility Related**						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	**TOTAL Non-Facility Related**						$	$			$	14
15	**TOTALS (line 9+line14)**						$	$			$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number APOSTOLIC CHRISTIAN TIMBER RIDGE **#** 0016220 **Report Period Beginning:** 07/01/2002 **Ending:** 06/30/2003

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2002 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$		2
3. Under or (over) accrual (line 2 minus line 1).	$		3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)	$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$		7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	1998	8
	1999	9
	2000	10
	2001	11
	2002	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2002	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME APOSTOLIC CHRISTIAN TIMBER RIDGE COUNTY TAZEWELL

FACILITY IDPH LICENSE NUMBER 0016220

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

Facility Name & ID Number APOSTOLIC CHRISTIAN TIMBER RIDGE # 0016220 Report Period Beginning: 07/01/2002 Ending: 06/30/2003

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 50,135 B. General Construction Type: Exterior brick Frame fireproof building Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

Oakwood Estate (IDPA #0033712) is located adjacent to this property.
Type of business: Nursing Home (ICF/DD-16)
Square footage: Land - 91,781 sq ft; Building - 7,140 sq ft

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Nursing Home	1,345,699	1969	$ 54,397	1
2					2
3	TOTALS	1,345,699		$ 54,397	3

Facility Name & ID Number APOSTOLIC CHRISTIAN TIMBER RIDGE # 0016220 Report Period Beginning: 07/01/2002 Ending: 06/30/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	44			1971	$ 650,091	$ 16,252	40	$ 16,252	$	$	4
5	54			1978	1,016,439	25,411	40	25,411			5
6											6
7											7
8											8
	Improvement Type**										
9	Sprinklers, smoke detectors			1977	15,687	392	40	392			9
10	Conference room			1979	20,973	524	40	524			10
11	Front entrance			1981	6,308	158	40	158			11
12	Sprinklers, security system			1982	7,002	175	40	175			12
13	Energy system			1983	5,725	143	40	143			13
14	Interior remodeling			1984	8,655	216	40	216			14
15	Storage addition			1985	25,692	642	40	642			15
16	Windows, furnace, improvements			1986	11,626	291	40	291			16
17	Redocorating, furnace, improvements			1987	42,953	1,074	40	1,074			17
18	Compressor, addition, office			1988	28,487	712	40	712			18
19	Office, patio, improvements			1988	26,716	668	40	668			19
20	Office, patio, improvements			1989	37,019	925	40	925			20
21	Flooring			1990	23,903	598	40	598			21
22	Roof, ceiling, flooring			1991	11,832	296	40	296			22
23	Flooring & improvements			1992	14,999	375	40	375			23
24	Roof			1994	31,810	795	40	795			24
25	Roofing			1995	17,217	430	40	430			25
26	Heat pump			1995	5,208	130	40	130			26
27	Remodel living room, lumber, windows			1995	10,408	260	40	260			27
28	Patio cover			1996	3,750	94	40	94			28
29	Magnetic Doors			1996	3,321	83	40	83			29
30	Floor covering			1997	850	21	40	21			30
31	Heat pumps & air conditioning units			1997	22,367	559	40	559			31
32	Heat pump & a/c installation			1998	2,696	67	40	67			32
33	Floor covering			1998	985	25	40	25			33
34	Wallpaper			1998	924	23	40	23			34
35	Bathroom remodeling			1998	1,657	41	40	41		1,311,500	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number APOSTOLIC CHRISTIAN TIMBER RIDGE # 0016220 Report Period Beginning: 07/01/2002 Ending: 06/30/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Patient hall bathroom	1999	$ 3,610	$ 90	40	$ 90	$	$ 405	37
38	Sprinkler heads	1999	3,690	92	40	92		414	38
39	Automatic doors	1999	9,356	234	40	234		1,053	39
40	Duct work	1999	1,082	27	40	27		122	40
41									41
42	Air conditioner	2000	1,882	47	40	47		165	42
43	Heat pump	2000	3,100	78	40	78		273	43
44	Automatic rear door	2000	1,773	44	40	44		154	44
45	Power panels/ generator	2000	14,000	350	40	350		1,225	45
46	Office window	2000	1,057	26	40	26		91	46
47	Exhaust fan	2000	580	15	40	15		51	47
48	Dining room remodeling	2000	10,565	264	40	264		924	48
49	Fire alarm relay	2000	2,400	60	40	60		210	49
50	Bathrooms - remodel	2000	22,147	554	40	554		1,939	50
51	Water coolers	2000	2,701	68	40	68		238	51
52	Roof repairs	2000	1,133	28	40	28		98	52
53									53
54	OT/PT decorating	2001	1,111	74	15	74		185	54
55	Slab jacking	2001	1,312	87	15	87		218	55
56	Roof replacement	2001	21,380	1,425	15	1,425		3,563	56
57	Roof replacement	2001	16,779	1,119	15	1,119		2,797	57
58	Lobby carpet and redecorating	2001	11,774	785	15	785		1,962	58
59	Dining room remodeling	2001	3,308	221	15	221		552	59
60	Additional QMRP (by activity rm.)	2001	2,393	160	15	160		400	60
61	Pipe insulation	2001	2,613	174	15	174		435	61
62	North resident renovation	2001	4,632	309	15	309		772	62
63	Activity room remodeling	2001	1,903	127	15	127		317	63
64	South whirlpool room	2001	2,676	178	15	178		445	64
65	Hand rails	2001	2,844	190	15	190		475	65
66	South living remodeling	2001	5,107	340	15	340		850	66
67	Hot water heater/ plumbing	2001	13,510	901	15	901		2,252	67
68	Heat pump	2001	4,694	313	15	313		782	68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,230,412	$ 59,760		$ 59,760	$	$ 1,334,867	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number APOSTOLIC CHRISTIAN TIMBER RIDGE # 0016220 Report Period Beginning: 07/01/2002 Ending: 06/30/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 2,230,412	$ 59,760		$ 59,760	$	$ 1,334,867	1
2	Key pad entry for south end	2002	2,500	167	15	167		250	2
3	Water heater plumbing	2002	706	47	15	47		71	3
4	Water heaters	2002	8,482	565	15	565		848	4
5	Lighting - small office in lobby	2002	545	36	15	36		54	5
6	Air conditioner - south living room	2002	3,196	213	15	213		320	6
7	HeatPump	2003	7,030	234	15	234		234	7
8	Land Improvements:								8
9	Improvements	1971	55,213		20			55,213	9
10	Improvements	1973	4,214		20			4,214	10
11	Drive, fence	1976	6,847		20			6,847	11
12	Landscaping	1979	30,551		20			30,551	12
13	Various	1980	15,117		20			15,117	13
14	Picnic area	1981	1,401		20			1,401	14
15	Fence	1983	5,880	146	20	146		5,881	15
16	Fence	1983	595	28	20	28		563	16
17	Patio	1984	978	50	20	50		932	17
18	Blacktop driveways	1985	22,000	1,100	20	1,100		19,250	18
19	South courtyard	1990	1,409	70	20	70		973	19
20	Irrigation, north courtyard	1989	2,585	129	20	129		1,806	20
21	Driveway, landscaping	1993	10,459	523	20	523		6,089	21
22	Sewer repair	1994	6,700	335	20	335		3,350	22
23	Tile and asphalt	1995	2,011	101	20	101		883	23
24	Asphalt	1997	15,136	757	20	757		5,298	24
25	Parking lot	1998	39,261	1,963	20	1,963		11,780	25
26	Repair asphalt	1999	3,500	175	20	175		788	26
27	Parking lot lights & installation	1999	4,000	200	20	200		900	27
28	Blacktop ramp at rear entrance	2001	770	77	10	77		193	28
29	Landscape drive entrance	2001	1,447	96	15	96		240	29
30	Landscape around building	2001	1,230	82	15	82		205	30
31	Various	1988	3,188		20			3,188	31
32	Sidewalk/ entry apron	2002	11,816	788	15	788		1,182	32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,499,179	$ 67,642		$ 67,642	$	$ 1,513,488	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number APOSTOLIC CHRISTIAN TIMBER RIDGE # 0016220 Report Period Beginning: 07/01/2002 Ending: 06/30/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 2,499,179	$ 67,642		$ 67,642	$	$ 1,513,488	1
2	Garage	1988	22,885	573	40	573		8,867	2
3	Storage Building	1973	9,065	226	40	226		6,718	3
4	Storage Bldg - addition	1981	4,660	117	40	117		2,622	4
5	Storage Bldg - addition	1982	21,495	538	40	538		11,554	5
6	Storage Bldg - addition	1983	126	3	40	3		64	6
7	Storage Bldg - improvements	1985	842	21	40	21		399	7
8	Garage door	1998	667	44	15	44		229	8
9	Garage lights	2001	1,400	93	15	93		233	9
10	Garage door	2002	594	40	15	40		59	10
11	Garage Roof and gutters	2003	9,587	320	15	320		320	11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,570,500	$ 69,617		$ 69,617	$	$ 1,544,553	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number APOSTOLIC CHRISTIAN TIMBER RIDGE # 0016220 Report Period Beginning: 07/01/2002 Ending: 06/30/2003

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 419,477	$ 47,088	$ 47,088	$		$ 219,200	71
72	Current Year Purchases	21,757	1,573	1,573			1,573	72
73	Fully Depreciated Assets	418,991	2,745	2,745			418,991	73
74								74
75	TOTALS	$ 860,225	$ 51,406	$ 51,406	$		$ 639,764	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 3,485,122	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 121,023	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 121,023	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,184,317	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Fully depreciated vehicles	$ 171,426	$ 1,578	$ 171,426	86
87	Capitalized repairs	28,587	3,977	9,388	87
88	High Top Van; 2000	34,410	6,882	24,087	88
89	1998 Ford Titan Van; 2000	18,577	3,715	13,004	89
90	Donated Used Vehicles (Bus and Van)	8,500	750	750	90
91	TOTALS	$ 261,500	$ 16,902	$ 218,655	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2004	$
13.	/2005	$
14.	/2006	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ X NO

16. Rental Amount for movable equipment: $ 3,791 Description: Food pump, oxygen concentrator
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number APOSTOLIC CHRISTIAN TIMBER RIDGE # 0016220 Report Period Beginning: 07/01/2002 Ending: 06/30/2003

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE 80

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE 40

B. EXPENSES

ALLOCATION OF COSTS (d)

			1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition		$	$	$	$
2	Books and Supplies		1,078	2,156		3,234
3	Classroom Wages	(a)	2,839	5,959		8,798
4	Clinical Wages	(b)	1,420	11,917		13,337
5	In-House Trainer Wages	(c)	6,267	26,303		32,570
6	Transportation					
7	Contractual Payments					
8	Nurse Aide Competency Tests					
9	TOTALS		$ 11,604	$ 46,335	$	$ 57,939
10	SUM OF line 9, col. 1 and 2	(e)	$ 57,939			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	30
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	15
2. From other facilities (f)	
TOTAL TRAINED	45

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number APOSTOLIC CHRISTIAN TIMBER RIDGE # 0016220 Report Period Beginning: 07/01/2002 Ending: 06/30/2003

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number APOSTOLIC CHRISTIAN TIMBER RIDGE **#** 0016220 **Report Period Beginning:** 07/01/2002 **Ending:** 06/30/2003

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 06/30/2003 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 566,118	$ 568,118	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (4,000))	775,646	993,203	3
4	Supply Inventory (priced at 41,627)	41,627	48,435	4
5	Short-Term Investments	3,564,361	3,564,361	5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	39,580	42,931	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Employee & other receivables	40,749	40,624	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 5,028,081	$ 5,257,672	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	300,705	709,190	13
14	Buildings, at Historical Cost	2,324,192	3,532,876	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,130,226	1,777,034	16
17	Accumulated Depreciation (book methods)	(2,402,973)	(3,203,751)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		38,156	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(38,156)	20
21	Restricted Funds	2,814,024	2,814,024	21
22	Other Long-Term Assets (spe Investment in other fa	3,161,482		22
23	Other(specify): Cash value life insurance	18,954	18,954	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 7,346,610	$ 5,648,327	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 12,374,691	$ 10,905,999	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 41,460	$ 57,092	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	251,912	339,455	30
31	Accrued Taxes Payable (excluding real estate taxes)	25,666	25,666	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation	131,373	176,213	34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 450,411	$ 598,426	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 450,411	$ 598,426	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 11,922,019	$ 10,307,573	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 12,372,430	$ 10,905,999	48

***(See instructions.)**

Facility Name & ID Number APOSTOLIC CHRISTIAN TIMBER RIDGE # 0016220 Report Period Beginning: 07/01/2002 Ending: 06/30/2003

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 11,715,327	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 11,715,327	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	206,692	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 206,692	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 11,922,019	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number APOSTOLIC CHRISTIAN TIMBER RIDGE # 0016220 Report Period Beginning: 07/01/2002 Ending: 06/30/2003

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,626,599	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,626,599	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants	76,257	10
11	Nurses Aide Training Reimbursements	57,170	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	8,254	16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 141,681	23
	D. Non-Operating Revenue		
24	Contributions	1,043,207	24
25	Interest and Other Investment Income***	(331,570)	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 711,637	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See attached schedule	481,318	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 481,318	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,961,235	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	876,214	31
32	Health Care	3,232,708	32
33	General Administration	1,207,005	33
	B. Capital Expense		
34	Ownership	167,529	34
	C. Ancillary Expense		
35	Special Cost Centers	1,943	35
36	Provider Participation Fee	269,144	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,754,543	40
41	**Income before Income Taxes (line 30 minus line 40)****	206,692	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 206,692	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** No **If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number APOSTOLIC CHRISTIAN TIMBER RIDGE # 0016220 Report Period Beginning: 07/01/2002 Ending: 06/30/2003

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,783	2,005	$ 59,951	$ 29.90	1
2	Assistant Director of Nursing	1,816	2,055	43,726	21.28	2
3	Registered Nurses	16,904	18,891	385,216	20.39	3
4	Licensed Practical Nurses	14,211	16,108	286,811	17.81	4
5	Nurse Aides & Orderlies					5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,874	2,202	40,344	18.32	9
10	Activity Assistants	17,370	18,728	182,803	9.76	10
11	Social Service Workers	1,109	1,217	11,858	9.74	11
12	Dietician					12
13	Food Service Supervisor	1,781	2,026	30,553	15.08	13
14	Head Cook					14
15	Cook Helpers/Assistants	21,134	23,625	222,254	9.41	15
16	Dishwashers					16
17	Maintenance Workers	4,337	5,047	79,696	15.79	17
18	Housekeepers	8,866	10,034	98,464	9.81	18
19	Laundry	9,605	11,607	117,359	10.11	19
20	Administrator	1,702	1,953	77,527	39.70	20
21	Assistant Administrator					21
22	Other Administrative	1,179	1,140	32,402	28.42	22
23	Office Manager	1,846	2,091	38,364	18.35	23
24	Clerical	2,511	3,430	34,197	9.97	24
25	Vocational Instruction	2,282	2,582	32,117	12.44	25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	8,753	9,755	145,482	14.91	28
29	Resident Services Coordinator	1,823	2,083	46,594	22.37	29
30	Habilitation Aides (DD Homes)	109,995	125,534	1,305,045	10.40	30
31	Medical Records					31
32	Other Health C: OT/PT/Speech	12,848	14,113	196,769	13.94	32
33	Other(specify) Day Programming	7,978	8,991	104,820	11.66	33
34	TOTAL (lines 1 - 33)	251,707	285,217	$ 3,572,352 *	$ 12.53	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	96	$ 4,494	1-3	35
36	Medical Director	flat fee	1,332	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	flat fee	2,279	10-3	39
40	Physical Therapy Consultant	66	3,622	10a-3	40
41	Occupational Therapy Consultant	88	4,794	10a-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	111	7,532	10a-3	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) Psychologist	38	4,200	12-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	399	$ 28,253		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	871	$ 28,624	10-3	50
51	Licensed Practical Nurses	1,583	48,234	10-3	51
52	Nurse Aides	2,710	49,547	13-3	52
53	TOTAL (lines 50 - 52)	5,164	$ 126,405		53

Facility Name & ID Number APOSTOLIC CHRISTIAN TIMBER RIDGE # 0016220 Report Period Beginning: 07/01/2002 Ending: 06/30/2003

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Ron Messner	Administrator	0	$ 77,527
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 77,527

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Howard & Howard	Legal	$ 691
Heinold Banwart, LTD	Acctg. & Counseling	14,904
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 15,595

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 99,907
Unemployment Compensation Insurance	4,898
FICA Taxes	270,675
Employee Health Insurance	322,958
Employee Meals	9,630
Illinois Municipal Retirement Fund (IMRF)*	
Retirement Plan	138,624
Employee Physicals	6,136
Employee Promotion	12,686
Benefits Allocated to Day Programming	(25,257)
Other	(139)
TOTAL (agree to Schedule V, line 22, col.8)	$ 840,118

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 400
Advertising: Employee Recruitment	5,992
Health Care Worker Background Check	714
(Indicate # of checks performed 60)	
Other dues	1,923
Promotion	2,597
IHCA dues	5,010
Other subscriptions	1,262
Chamber of Commerce dues	375
Driving records verification	318
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 18,591

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
Board of Directors travel	2,761
Administrative travel	1,168
In-State Travel	
Board of Directors travel	482
Administrative travel	1,197
Seminar Expense	
Less out of state travel	(3,929)
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,679

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number APOSTOLIC CHRISTIAN TIMBER RIDGE # 0016220 Report Period Beginning: 07/01/2002 Ending: 06/30/2003

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number APOSTOLIC CHRISTIAN TIMBER RIDGE # 0016220 Report Period Beginning: 07/01/2002 Ending: 06/30/2003

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois Health Care Association - $5010**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? _____

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **15 yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **53,925** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? _____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

_____

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **269,144**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **Yes** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **Yes** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **9,283** Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No, they have been adjusted out.**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **Yes** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **8,448**
c. What percent of all travel expense relates to transportation of nurses and patients? **88%**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? Yes
Indicate the amount of income earned from providing such transportation during this reporting period. $ **67,809**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Heinold-Banwart, LTD.** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **Yes** If no, please explain. _____

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.

Apostolic Christian Timber Ridge
FYE 6/30/2003 **#016220**
Subschedules

Schedule V - Costs per General Ledger

Lines	Description	Amount
43	Facility Bulletin / Newsletter	1,943
	Other Expenses	1,943

Schedule V - Reclassifications

Lines	Description	Amount Increase	Amount Decrease
21	Communication equipment rental	644	
35	Communication equipment rental		644
11	Donated labor	400	
4	Donated labor	466	
6	Donated labor	9,011	
21	Donated labor	851	
10a	Donated labor	44	
12	Donated labor	122	
27	Donated labor		10,894
38	Medically necessary transportation	8,448	
14	Medically necessary transportation		8,448
13	Nurse aid trainer wages	32,570	
1	Nurse aid trainer wages		125
6	Nurse aid trainer wages		185
10	Nurse aid trainer wages		18,309
10a	Nurse aid trainer wages		1,631
11	Nurse aid trainer wages		229
12	Nurse aid trainer wages		11,807
17	Nurse aid trainer wages		284
39	Dental costs	9,250	
27	Dental costs		9,250
		61,806	61,806

Schedule V, Line 39 - Ancillary Service Centers

Dental costs for 138 visits	$ 9,250

Schedule VI B - Non-paid workers

Lines	Description	Amount
31	Donated Labor	$ 10,894
Department	Time in Hours	Time in Dollars
Activities	72.75	400
Laundry	84.75	466
Maintenance	977.00	9,011
Office	56.75	851
PT/OT	8.00	44
Social Service Programs	22.25	122
Totals	1,221.50	$ 10,894

Schedule VII - Compensation Received From Other Nursing Homes

Stan Virkler - $152 - reimbursement of travel expenses received from Oakwood Estate & Linden Estate
Ron Gasser - $619 - reimbursement of travel expenses received from Oakwood Estate & Linden Estate
Keith Pflum - $263 - reimbursement of travel expenses received from Oakwood Estate & Linden Estate
Warren Zahner - $748 - reimbursement of travel expenses received from Oakwood Estate & Linden Estate

Sch. XV - Balance Sheet, Line 22; Other Long-Term Assets

Investment in Related Entities	3,161,482

Sch. XVII - Income Statement, Line 28; Other Revenue

Developmental training	470,357
Farm income	800
Employee Meals	3,493
	474,650

Sch. XVII - Income Statement, Line 41 - Income Before Taxes

Income before taxes per cost report	206,692
Income from related parties	173,526
Estimated excess for year, Form 990, p.1, line 18	380,218

Schedule XIX, D - Employee Benefits and Payroll Taxes - FICA calculation

Salaries, Sch V, Line 45, Col 1	3,572,352
Add accrued wages a/o 6/30/02	83,051
Less accrued wages a/o 6/30/03	(105,203)
Add wages included in employee meal calculation	6,018
Cash basis salaries	3,556,218
FICA rate	0.0765
Calculated FICA	272,051
FICA per Sch XIX	270,675
Unknown variance	1,376

Sch. XX - General Information

12. Nurse Aide Trainer Wages:

Administrator	284
Therapy / PT / OT	1,631
Activities Director	229
Head Cook	125
Maintenance	185
Nursing	18,309
Soc. Serv. / QMRP	11,807
	32,570

14. A portion of office space is allocated to related entities based on number of beds.

16. Out of State Travel

Administration	
Ron Messner	1,168
	1,168
Board of Directors	
Ron Gasser	1,135
Stan Virkler	274
Warren Zahner	1,352
	2,761

APOSTOLIC CHRISTIAN TIMBER RIDGE, #0016220

ATTACHMENT TO SCH VII A

Related Organizations:

Oakwood Estate, Morton, IL #0033712
Linden Estate, Morton, IL #0039305

Board of Directors for Apostolic Christian Timber Ridge, Oakwood Estate, and Linden Estate:

Edward Sauder, Chairman
John Knobloch, Vice Chairman
Dan Schumacher, Secretary/ Treasurer
Jerry Christensen, Director
Ron Gasser, Director
Jerry Kieser, Director
Keith Pflum, Director
Richard Steffen, Director
Warren Zahner, Director
Stan Virkler, Director

Note: The Board members are identical for all three organizations.

No members of the Board of Directors provided direct services to any of the nursing homes. No Board members have ownership in an entity that conducted business transactions with any of these nursing homes.

APOSTOLIC CHRISTIAN TIMBER RIDGE, #0016220

	Pioneer Park	PARC	Van-Pioneer Park	Cost per Trip	Cost per Day		Total Cost per Year	Less Depreciation	Reallocation Amounts	Sch. V Col. 7 Line #	Schedule for Reallocation
Trips per Day	2	2	1								
Miles per trip	40	40	40								
Gas/Depreciation Price per Mile	$0.65	$0.75	$0.35								
Hours per trip	1 1/4	1 1/4	1 1/4								
Attendant Wages	$7.75	$7.75									
Driver Wages	$12.00	$12.00	$10.00								
Gas & Depreciation	$ 26.00	$ 30.00	$ 14.00	$ 70.00	**$ 126.00**	53.11%	**36,011.08**	(16,902.00)	**19,109.00**	14	**Sch. VI Ln. 29**
Depreciation					**$ -**			16,902.00	**16,902.00**	Sch XI (F)	**Sch. VI Ln. 29**
Driver Wages	$ 15.00	$ 15.00	$ 12.50	$ 42.50	**$ 72.50**	30.56%	**20,720.66**		**20,721.00**	6	**Sch. VI Ln. 1**
Attendant Wages	$ 9.69	$ 9.69	$ -	$ 19.38	**$ 38.76**	16.34%	**11,077.69**		**11,078.00**	10	**Sch. VI Ln. 29**
Total	$ 50.69	$ 54.69	$ 26.50	$ 131.88	**$ 237.26**		**67,809.44**		**67,810.00**		

AIDE CLASSES - 7/1/02 -6/30/03 **APOSTOLIC CHRISTIAN TIMBER RIDGE, #0016220**

CLASS DATE		TR					OE					*LE*					*CILA*				
		# of	CLASS		OJT		# of	CLASS		OJT		# of	CLASS		OJT		# of	CLASS		OJT	
		Students	*Hrs*	Wages	*HRS*	Wages	Students	*Hrs*	Wages	*HRS*	Wages	Students	*Hrs*	Wages	*HRS*	Wages	Students	*Hrs*	Wages	*HRS*	Wages
completed	**38**	29	661	$ 5,618.50	*1322*	$ 11,237.00	2	80	$ 680.00	160	$ 1,360.00	2	62	$ 527.00	124	$ 1,054.00	5	192	$ 1,632.00	384	$ 3,264.00
still enrolled, not complete	**2**	1	*40*	$ 340.00	*80*	$ 680.00	0	*0*	$ -			0					1	7	$ 59.50	14	$ 119.00
dropouts	**16**	15	*167*	$ 1,419.50	*334*	$ 2,839.00	0	*0*	$ -			0					1	40	$ 340.00	80	$ 680.00
				$ -	*0*	$ -			$ -												
				$ -	*0*	$ -			$ -												
				$ -	*0*	$ -			$ -												
Total	1249	45	868	$ 7,378.00	1736	$ 14,756.00	2	80	$ 680.00	160	$ 1,360.00	2	62	$ 527.00	124	$ 1,054.00	7	239	$ 2,031.50	478	$ 4,063.00
				$ -					$ -												
									$ -												

TRAINER WAGES		hrlyrate	wages	hrs/class	TR	OE	LE	CILA	TR	OE	LE	CILA
Stephen Mattern, PT/OT	*48*	$ 20.01	$ 960.48	8.0	667.49	61.52	47.68	183.79	33.36	3.07	2.38	9.18
Kevin Pilger, Activities	*18*	$ 18.28	$ 329.04	3.0	228.67	21.08	16.33	62.96	12.51	1.15	0.89	3.44
Lori Brittain, Dietary	*12*	$ 15.03	$ 180.36	2.0	125.34	11.55	8.95	34.51	8.34	0.77	0.60	2.30
Gary Folkerts, Maintenance	*12*	$ 22.23	$ 266.76	2.0	185.39	17.09	13.24	51.05	8.34	0.77	0.60	2.30
Maurine Collett, DON	*18*	$ 29.83	$ 536.94	3.0	373.15	34.39	26.65	102.75	12.51	1.15	0.89	3.44
Marcella Chapman, Asst. DON	*18*	$ 21.50	$ 387.00	3.0	268.95	24.79	19.21	74.05	12.51	1.15	0.89	3.44
Q's	*60*	$ 16.15	$ 969.00	10.0	673.41	62.07	48.10	185.42	41.70	3.84	2.98	11.48
Speech	*36*	$ 14.70	$ 529.20	6.0	367.77	33.90	26.27	101.26	25.02	2.31	1.79	6.89
Randy Mogler,RSD	*24*	$ 22.22	$ 533.28	4.0	370.61	34.16	26.47	102.04	16.68	1.54	1.19	4.59
Day Program	*0*	$ 17.39	$ -	0.0	-	-	-	-	-	-	-	-
Lynn Wuthrich- Soc. Services(OJT trainer)	*1240*	$ 12.92	$ 16,020.80	40.0	11,133.75	1,026.15	795.27	3,065.63	861.75	79.42	61.55	237.28
Anna Liza Raboza -RN(OJT trainer)	*1240*	$ 20.50	$ 25,420.00	40.0	17,665.78	1,628.18	1,261.84	4,864.20	861.75	79.42	61.55	237.28
Resident Aide	*30*	$ 10.80	$ 324.00	5.0	225.17	20.75	16.08	62.00	20.85	1.92	1.49	5.74
OE	*0*		$ -		-	-	-	-	-	-	-	-
Helen Schuon	*18*	$ 22.74	$ 409.32	3.0	284.46	26.22	20.32	78.32	12.51	1.15	0.89	3.44
					32,569.93	3,001.84	2,326.42	8,967.99	1,927.81	177.68	137.70	530.81

	TR	OE	LE	CILA
Drop-Outs				
Number from this Facility	15	0	0	1
Clinical Wages	$ 2,839.00	$ -	$ -	$ 680.00
Classroom Wages	$ 1,420.00	$ -	$ -	$ 340.00
In-House Trainer Wages	$ 2,090.00	$ -	$ -	$ 500.00
Completed				
Number from this Facility	30	2	2	6
Clinical Wages	$ 5,959.00	$ 680.00	$ 527.00	$ 1,692.00
Classroom Wages	$ 11,917.00	$ 160.00	$ 1,054.00	$ 3,383.00
In-House Trainer Wages	$ 17,536.00	$ 572.00	$ 1,551.00	$ 4,978.00

	Line	Change	Change	Change	Change
Dietary	1	(125.00)	(12.00)	(9.00)	(35.00)
Maintenance	6	(185.00)	(17.00)	(13.00)	(51.00)
Nursing	10	(18,308.00)	(1,687.00)	(1,308.00)	(5,041.00)
Activities	11	(229.00)	(21.00)	(16.00)	(63.00)
Social Services	12	(11,134.00)	(1,026.00)	(795.00)	(3,066.00)
QMRP's	12	(673.00)	(62.00)	(48.00)	(185.00)
Training Wages	13	32,570.00	3,002.00	2,326.00	8,968.00
Day Program	15	-	-	-	-
Administrator	17	(284.00)	(26.00)	(20.00)	(78.00)
Therapy	10a	(964.00)	(89.00)	(69.00)	(265.00)
OT/PT	10a	(667.00)	(62.00)	(48.00)	(184.00)

APOSTOLIC CHRISTIAN TIMBER RIDGE -- 0016220

	Salary/Wage	Supplies	Other	Total	Reclass-ification	Total	Adjust-ments	Adjusted Total	Cost / Day Resident Days 34,828	% of Total Costs	% of Rate	Staff Hours/ Day
A. General Services												
Dietary	252,807	13,235	4,494	270,536	(125)	270,411	-	270,411	$7.76	4.9%	5.9%	0.66
Food Purchase	-	158,982	-	158,982	-	158,982	-	158,982	$4.56	2.9%	3.5%	
Housekeeping	98,464	11,816	-	110,280	-	110,280	-	110,280	$3.17	2.0%	2.4%	0.25
Laundry	117,359	9,983	-	127,342	466	127,808	-	127,808	$3.67	2.3%	2.8%	0.28
Heat and Other Utilities	-	-	75,679	75,679	-	75,679	-	75,679	$2.17	1.4%	1.6%	
Maintenance	79,696	18,711	32,727	131,134	8,826	139,960	(20,721)	119,239	$3.42	2.2%	2.6%	0.12
Other (specify):*	-	-	2,261	2,261	-	2,261	(2,261)	-	$0.00	0.0%	0.0%	
TOTAL General Services	**548,326**	**212,727**	**115,161**	**876,214**	**9,167**	**885,381**	**(22,982)**	**862,399**	**$24.76**	**15.7%**	**18.8%**	**1.31**
B. Health Care and Programs												
Medical Director	-	-	1,332	1,332	-	1,332	-	1,332	$0.04	0.0%	0.0%	
Nursing and Medical Records	775,704	176,692	82,201	1,034,597	(18,309)	1,016,288	(11,078)	1,005,210	$28.86	18.2%	21.9%	1.00
Therapy	1,531,876	5,751	65,495	1,603,122	(1,587)	1,601,535	-	1,601,535	$45.98	29.1%	34.9%	3.53
Activities	223,147	8,390	-	231,537	171	231,708	-	231,708	$6.65	4.2%	5.0%	0.55
Social Services	183,854	2,153	4,200	190,207	(11,685)	178,522	-	178,522	$5.13	3.2%	3.9%	0.34
Nurse Aide Training	22,135	3,234	-	25,369	32,570	57,939	-	57,939	$1.66	1.1%	1.3%	0.07
Program Transportation	-	-	39,477	39,477	(8,448)	31,029	(19,109)	11,920	$0.34	0.2%	0.3%	
Other (specify):*	104,820	2,247	-	107,067	-	107,067	(107,067)	-	$0.00	0.0%	0.0%	
TOTAL Health Care and Programs	**2,841,536**	**198,467**	**192,705**	**3,232,708**	**(7,288)**	**3,225,420**	**(137,254)**	**3,088,166**	**$88.67**	**56.1%**	**67.3%**	**5.48**
C. General Administration												
Administrative	77,527	-	-	77,527	(284)	77,243	-	77,243	$2.22	1.4%	1.7%	0.05
Directors Fees	-	-	-	-	-	-	-	-	$0.00	0.0%	0.0%	
Professional Services	-	-	20,012	20,012	-	20,012	-	20,012	$0.57	0.4%	0.4%	
Dues, Fees, Subscriptions & Promotions	-	-	21,026	21,026	-	21,026	(5,432)	15,594	$0.45	0.3%	0.3%	
Clerical & General Office Expenses	104,963	31,640	15,657	152,260	1,495	153,755	-	153,755	$4.41	2.8%	3.4%	0.16
Employee Benefits & Payroll Taxes	-	-	865,514	865,514	-	865,514	(25,396)	840,118	$24.12	15.2%	18.3%	
Inservice Training & Education	-	-	4,612	4,612	-	4,612	-	4,612	$0.13	0.1%	0.1%	
Travel and Seminar	-	-	5,608	5,608	-	5,608	(3,929)	1,679	$0.05	0.0%	0.0%	
Other Admin. Staff Transportation	-	-	-	-	-	-	-	-	$0.00	0.0%	0.0%	
Insurance-Prop.Liab.Malpractice	-	-	40,002	40,002	-	40,002	-	40,002	$1.15	0.7%	0.9%	
Other (specify):*	-	-	20,444	20,444	(20,144)	300	(300)	-	$0.00	0.0%	0.0%	
TOTAL General Administration	**182,490**	**31,640**	**992,875**	**1,207,005**	**(18,933)**	**1,188,072**	**(35,057)**	**1,153,015**	**$33.11**	**20.9%**	**25.1%**	**0.21**
TOTAL Operating Expense	**3,572,352**	**442,834**	**1,300,741**	**5,315,927**	**(17,054)**	**5,298,873**	**(195,293)**	**5,103,580**	**$146.54**	**92.6%**	**111.2%**	**7.00**
D. Ownership												
Depreciation	-	-	138,659	138,659	-	138,659	(16,902)	121,757	$3.50	2.2%	2.7%	
Amortization of Pre-Op. & Org.	-	-	-	-	-	-	-	-	$0.00	0.0%	0.0%	
Interest	-	-	158	158	-	158	-	158	$0.00	0.0%	0.0%	
Real Estate Taxes	-	-	-	-	-	-	-	-	$0.00	0.0%	0.0%	
Rent-Facility & Grounds	-	-	-	-	-	-	-	-	$0.00	0.0%	0.0%	
Rent-Equipment & Vehicles	-	-	4,435	4,435	(644)	3,791	-	3,791	$0.11	0.1%	0.1%	
Other (specify):*	-	-	24,277	24,277	-	24,277	(24,277)	-	$0.00	0.0%	0.0%	
TOTAL Ownership	**-**	**-**	**167,529**	**167,529**	**(644)**	**166,885**	**(41,179)**	**125,706**	**$3.61**	**2.3%**	**2.7%**	**-**
Ancillary Expense												
E. Special Cost Centers												
Medically Necessary Transportation	-	-	-	-	8,448	8,448	(8,448)	-	$0.00	0.0%	0.0%	
Ancillary Service Centers	-	-	-	-	9,250	9,250	-	9,250	$0.27	0.2%	0.2%	
Barber and Beauty Shops	-	-	-	-	-	-	-	-	$0.00	0.0%	0.0%	
Coffee and Gift Shops	-	-	-	-	-	-	-	-	$0.00	0.0%	0.0%	
Provider Participation Fee	-	-	269,144	269,144	-	269,144	-	269,144	$7.73	4.9%	5.9%	
Other (specify):*	-	-	1,943	1,943	-	1,943	-	1,943	$0.06	0.0%	0.0%	
TOTAL Special Cost Centers	**-**	**-**	**271,087**	**271,087**	**17,698**	**288,785**	**(8,448)**	**280,337**	**$8.05**	**5.1%**	**6.1%**	**-**
GRAND TOTAL COST	**3,572,352**	**442,834**	**1,739,357**	**5,754,543**	**-**	**5,754,543**	**(244,920)**	**5,509,623**	**$158.20**	**100.0%**	**120.0%**	**7.00**
Current Reimbursement Rate									**$131.78**	**83.3%**	**100.0%**	
Gain/(Loss) Per Resident / Day									**(26.42)**	**-16.7%**	**-20.0%**	
									-20.0%			
% of Costs Per Area	**77.12%**	**7.70%**	**15.19%**	**100.00%**